DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-24

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.325, 42 CFR 440.130(d)

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ -$9,740,520
b. FFY 02 $ 19,937,276

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
* 15a.1 and 15a.2
Attachment 3.1-A.1 Page ~~XXXXXX~~
Attachment 4.19-B, Section 13, Page 1,
* Page 2, and Page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~XXXXXX~~ Attachment 4.19-B, Section 13, Page 1
* Attachment 3.1-A.1Page 15b

10. SUBJECT OF AMENDMENT:
Other Diagnostic, Screening, Preventive and Rehabilitative Services

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
H. David Bruton

14. TITLE:
Secretary

15. DATE SUBMITTED:
December 21, 2000

16. RETURN TO:
Office of the Secretary
Department of Health & Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 29, 2000

18. DATE APPROVED:
July 30, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:
State Agency authorized "pen and ink" changes to show page re-numbering.
State Agency authorized "pen and ink" addition to Regulation Citation.

FORM HCFA-179 (07-92)

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13. OTHER DIAGNOSTIC SCREENING PREVENTIVE AND REHABILITATIVE SERVICES

Payments for other diagnostic screening, preventive and rehabilitative services provided by qualified providers are based on rates established by the Division of Medical Assistance for each type of covered service. Beginning with the 12 month period starting July 1, 1999, and for subsequent 12 month periods, the interim rates for public providers are based on the analysis of actual average unit cost of each type of service from the most recent cost reports available, or determined by the Division of Medical Assistance. Said interim rates are subject to inflation. The inflation has a labor component with a relative weight of 75 percent and a non-labor component with a relative weight of 25 percent. The relative weights are derived from the Medicare Home Health Agency Input Price Index published in the Federal Register dated May 30, 1986. Labor cost changes are measured by the annual percentage change in the average hourly earnings of North Carolina service wages per worker. Non-labor cost changes are measured by the annual percentage change in the GNP Implicit Price deflator. The annual inflation equals the sum of the products of multiplying the forecasted labor cost percentage change by 75 percent and multiplying the forecasted non-labor cost percentage change by 25 percent.

The interim rates for public providers are settled annually to equal the weighted average unit cost as determined by the Division of Medical Assistance's review of the public provider's cost. Reasonable costs are determined by the Division of Medical Assistance based upon the standards set in OMB Circular A-87 and the HCFA-15 Provider Reimbursement Manual.

The Division will establish prospective rates with private providers of services based upon a Division determination of reasonable cost. Private providers shall be required to file annual cost reports. These rates will be adjusted annually for inflation. The inflation methodology for private providers shall be the same as that described above for public providers. Reasonable costs are determined by the Division of Medical Assistance

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based upon the standards set in the HCFA-15 Provider Reimbursement Manual. Assets with a cost greater than five hundred dollars and a useful life of more than two years shall be capitalized and subject to depreciation. Reasonable costs are set to reflect the lower of the unit cost as determined by the Division of Medical Assistance or the 50th percentile of unit cost determined by arraying all unit costs from low to high and their corresponding total service units. The 50th percentile unit cost is found at the point in which the sum of service units adding the service units from the lowest cost per unit to the highest cost per unit equals 50 percent of the total of all service units.

The Division's determination of reasonable cost shall take into full consideration only the cost of service related to providing Medicaid covered services. Rates shall be established at a level no greater than reasonable cost. Any costs related to non-Medicaid covered services shall be excluded from the rate determination process.

The direct costs of the service claimed must be (a) necessary and reasonable, (b) allocable to the service, (c) not prohibited or limited by Federal or State laws and regulations, (d) accorded a consistent treatment (meaning costs should be claimed as either a direct cost or an indirect cost repeatedly), (e) determined in accordance with applicable cost principles, and (f) not included as a cost or used to meet cost sharing or matching requirements of any other Federal award or program in either the current or a prior period, except as specifically provided by Federal law or regulation.

Direct costs usually include those costs identified specifically with a particular final cost objective, such as the salaries of workers performing case management services. Typically, direct costs include employee salary and fringe benefits for the time devoted and identified specifically to the performance of that service (including supervision); cost of materials acquired, consumed, or expended specifically for the purpose of the service; equipment and other approved capital expenditures; travel and other expenses incurred specifically to carry out the service.

Indirect costs, are those costs (a) incurred for a common or joint purpose benefiting more than one cost objective and (b) not readily assignable to a cost objective, and should be distributed to benefiting cost objectives using a basis that would result in an

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equitable allocation related to the benefits derived. This usually includes salaries of staff supporting the provision of the service, employee fringe benefits, other non-salary costs such as building and equipment maintenance and depreciation, insurance expenses,
utilities, training expenses, and material and supply expenses, among others.

The services covered under this section are included under Attachment 3.1-A.1 Pages 15a.1 and 15a.2 of the state plan. These services are reimbursed on the basis of either a periodic fee schedule or a per diem.

No payments are included for room and board costs.

The facilities providing these services are not IMD facilities.

C. High Risk Intervention services for EPSDT eligible children are provided under this section. The services comprise a treatment component package, which may be provided in supervised residential settings. A physician or a Ph.D. psychologist orders these services. A treatment plan must be in place. The population served is for children under 21 years of age that have mental health or substance abuse service needs. This service would only be provided for the developmentally disabled population less than 21 years of age if they have a dual diagnosis, MR along with MI or SA, and medical necessary services are needed for MI/SA. The CFR reference is CFR 42 440. 130. The residential living situation is not compensated for room and board.

High Risk Intervention services has four levels of care.

Level I

Level I is a low to moderate structured and supervised environment level of care provided in a family setting. Services provided include: mentoring, minimal staff/support/supervision in all identified need areas, minimal assistance with adaptive skill training in all functional domains, behavioral interventions for mildly disruptive behaviors, minimal assistance with community integration activities, and stress management. Modeling, providing positive reinforcement when needed, teaching social skills, daily living skills, anger management, family living skills and communication skills are all part of the treatment component.

Level II

Level II is a moderate to high structured supervised environment level of care provided in a group home (a minimum of one staff is required per four consumers at all times) or a family setting (one or two consumers per home). This service in the family or program settings includes all of Level I elements plus provision of a more intensive corrective relationship in which therapeutic interactions are dominant. There is a higher level of supervision and structure. Provider requirements for Program Type Residential Treatment is a high school education/GED or an associate degree with one year experience; or a four-year degree in the human service field; and / or must meet requirements established by the state personnel system or equivalent for job classifications.

Skills and competencies of this service provider must be at a level, which offer psychoeducational relational support, behavioral modeling interventions and supervision. Additionally, special training of the caregiver is required in all aspects of sex offender specific treatment. A qualified professional is also available oncall. Implementation of therapeutic gains is to be the goal of the placement setting.

Level III

Level III is a highly structured and supervised environment level of care in a program setting only. All elements of Family/Program-Type Residential Treatment (Levels I, II) are provided plus intensified structure, supervision, and containment of frequent and highly inappropriate behavior. This setting is typically defined as being "staff secure". Staff is present and available at all times of the day, including overnight awake.

A minimum of one staff is required per four consumers at all times.
Staffing requirements are: minimal requirement is a high school diploma/GED, associate degree with one year experience; or a four-year degree in the human service field and / or a combination of experience, skills, and competencies that is equivalent. Skills and competencies of this service provider must be at a level which offer pychoeducational relational support, and behavioral modeling interventions and supervision and / or must meet requirements established by the state personnel system or equivalent for job classifications. These preplanned, therapeutically structured interventions occur as required in all aspects of sex offender specific treatment. Implementation of therapeutic gains is to be the goal of the placement setting. Additionally, consultative and treatment services at a Qualified Professional level shall be available no less than four hours per week. This staff may include a social worker, psychologist , or a psychiatrist. These services must be provided at the facility.

Level IV

Level IV is a level of care provided in a physically secure, locked environment in a program setting. All elements of Level III care are included in Level IV plus ability to to manage intensive levels of aggressiveness. Supervision is continuous. Staff is present and available at all times of the day, including overnight awake. A minimum of two direct care staff are required per six consumers at all times. Additionally, consultative and treatment services at a Qualified Professional level shall be available no less than eight hours per week. Staffing provisions apply as with Level III. Provider requirements are as follows: minimal requirement is a high school diploma / GED, associate degree with one year experience or a four-year degree in the human service field and / or a combination of experience, skills and competencies that is equivalent.

Skills and competencies of this service provider must be at a level that include structured interventions in a contained setting to assist the consumer in acquiring control over acute behaviors. In addition, special training of the caregiver is required in all aspects of sex offender specific treatment; and /or the provider must meet requirements established by the state personnel system or the equivalent for job classifications. Implementation of therapeutic gains is to be the goal of the placement setting.